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SUBSTANCE ABUSE

Project on identification and management of alcohol-related problems.

Report on Phase II: A randomized clinical trial of brief interventions in primary health care

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ABSTRACT

This report describes the rationale, methodology and findings of a cross-national multicentre clinical trial of brief intervention procedures designed to reduce the health risks associated with hazardous alcohol use. The study was coordinated by the World Health Organization at collaborating centres in ten countries: Costa Rica, Australia, the United Kingdom, Norway, Mexico, Kenya, Bulgaria, the former Soviet Union, Zimbabwe, and the United States of America. A total of 1,655 nonalcoholic heavy drinkers (1,356 males, 299 females) were recruited from hospital settings, primary health care clinics, work sites and educational institutions. Of these, 73% were evaluated a minimum of six months following random assignment to either a control group, a simple advice group, or a group receiving brief counselling. The results showed a significant effect of the interventions on both average alcohol consumption and intensity of drinking in the male samples, even after controlling for demographic factors and sociocultural influences. For females significant reductions were observed in both the control and the intervention groups. The type of intervention was not related to the amount of change in drinking behaviour, with five minutes of simple advice as effective as 20 minutes of brief counselling. It is concluded that brief intervention techniques could make a significant contribution to early intervention and secondary prevention if they were widely used in primary care settings.

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TABLE OF CONTENTS

CHAPTER	TITLE	PAGE
	Acknowledgements	v
1.	Summary and conclusions	1
2.	Background to the study	5
3.	Experimental design and project administration	15
4.	Baseline comparisons: Demographic characteristics, alcohol consumption patterns and alcohol-related problems	57
5.	Centre report: **Sydney, Australia**	73
6.	Centre report: **Pleven, Bulgaria**	91
7.	Centre report: **San José, Costa Rica**	103
8.	Centre report: **Nairobi, Kenya**	113
9.	Centre report: **Mexico City, Mexico**	129
10.	Centre report: **Bergen, Norway**	143
11.	Centre report: **Moscow, USSR**	157
12.	Centre report: **Cardiff, UK**	175
13.	Centre report: **Farmington, USA**	191
14.	Centre report: **Harare, Zimbabwe**	211
15.	How brief intervention works: Representative cases as viewed by the health advisers	221
16.	Combined analyses of outcome data: The cross-national generalizability of brief interventions	233
17.	Towards a public health approach to secondary prevention: Clinical and policy implications	259

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WORLD HEALTH ORGANIZATION
Project on Identification and Management
of Alcohol-related Problems

Report on Phase II:
A Randomized Clinical Trial of Brief Interventions
in Primary Health Care

Chapter 1

SUMMARY AND CONCLUSIONS

This report describes the rationale, methodology and findings of a cross-national multicentre clinical trial of brief intervention procedures designed to reduce the health risks associated with hazardous alcohol use. The aims of the project were: 1) to study the influence of simple advice and brief counselling on the frequency and quantity of drinking; 2) to investigate the moderating róle of reduced consumption on the prevention of alcohol-related problems, and 3) to evaluate the cross-national generalizability of brief intervention techniques.

The study was coordinated by the World Health Organization, Division of Mental Health, at collaborating centres located in ten countries: Costa Rica, Australia, the United Kingdom, Norway, Mexico, Kenya, Bulgaria, the Soviet Union, Zimbabwe, and the United States of America. The study tested the hypothesis that the amount of change in alcohol consumption over a six month period is proportional to the intensity of the intervention provided by a trained primary care health professional, with increasing benefit resulting from simple advice, brief counselling, and extended counselling, respectively. In addition, the study evaluated whether patients who reduced their drinking would also experience fewer alcohol-related problems.

After presenting the rationale for conducting the project (Chapter 2), the research procedures employed by the collaborating centres are described (Chapter 3). A total of 1,655 nonalcoholic heavy drinkers (1,356 males, 299 females) were recruited from a combination of hospital settings, primary care clinics, work sites and educational institutions. Of these, 73% were evaluated a minimum of six months following random assignment to either control or intervention conditions. Eight centres followed a "core" research design that consisted of randomly assigning heavy drinkers to either a control group, a simple advice group, or a group receiving brief counselling. (One centre was unable to randomize patients to an untreated control group, using standard outpatient treatment as a comparison condition instead. Another centre did not randomize patients but did compare matched groups.) In the core design, the control group received only a 20-minute health interview. These individuals were then contacted six months later for a follow-up evaluation. The Simple Advice group was exposed to the same general health interview plus five minutes of advice about the importance of sensible drinking or abstinence. The Brief Counselling group received the same five minutes of advice as well as an additional 15-minutes of counselling. The Brief Counselling group also received a self-help manual that they were encouraged to use in the development of a "habit-breaking plan".

Collaborating investigators could also add optional conditions to the core research design in order to explore additional research questions that were considered too expensive or time consuming for all

centres to pursue. Six centres added an "extended counselling" condition that consisted of the initial brief counselling sessions followed by three more meetings with the health worker to monitor progress during the next six months. Two centres studied the effects of nonspecific health counselling on drinking by adding conditions that controlled for the time and attention given to the patient.

Chapter 4 compares descriptive information from the ten centres. These data show that the samples differed significantly in terms of demographic characteristics, drinking patterns, average daily alcohol consumption and alcohol-related problems. In general, patients recruited from Bergen, Moscow, San José, and Mexico City tended to be admitted to the study on the basis of their frequency of intoxication, while those recruited from the other centres were considered appropriate because of the high average levels of daily consumption. Either pattern of consumption, occurring in the absence of serious dependence symptoms, qualified the patient for inclusion in the study, based on the assumption that both frequent intoxication and high daily alcohol intake are risk factors that warrant intervention at the primary care level. While the samples recruited into this study cannot be assumed to be representative of the broader cultures they belong to, the findings are consistent with the different patterns of drinking known to exist in these countries.

In addition to the comparison of demographic data and various drinking measures, multiple classification analysis was conducted to evaluate a major premise of the investigation. This premise is that the average level of alcohol consumption and the intensity of drinking should place heavy drinkers at risk of various alcohol-related problems, regardless of cultural setting. To examine this assumption, two indices of alcohol consumption (total amount of alcohol typically consumed per month and intensity of drinking on a typical drinking day) were examined in relation to various indicators of alcohol-related consequences, including physical complaints, hypertension, traumatic injury, affective disregulation, concern expressed by others and psychosocial problems. The results showed that for both men and women, alcohol-related consequences in practically every category varied directly with the average amount of daily consumption and the intensity of drinking per occasion. These findings were obtained even after controlling for the effects of sociodemographic variables (age and education) and sociocultural differences among the centres. The findings indicate that the pattern and amount of alcohol consumption are important mediators of adverse consequences, and suggest that interventions designed to reduce the quantity and frequency of drinking should reduce the risk of alcohol-related problems.

The outcome results of the ten parallel studies are presented in Chapters 5 through 14. These centre reports also describe the typical drinking patterns of each country, the problems associated with alcohol misuse, and the management of alcohol-related problems within that nation's health system. The results of the individual centre studies showed that significant reductions could be attributed directly to the interventions in at least one of the primary dependent measures (average daily alcohol consumption and intensity of drinking) at five sites (Australia, UK, USSR, USA and Zimbabwe) for male heavy drinkers. Two centres (Mexico and Kenya) showed comparable reductions in both the control and intervention groups, and two centres (Norway and Bulgaria) showed no changes. One centre (Costa Rica) that assigned patients to standard treatment instead of an untreated control group found that simple advice and brief counselling were as effective as more intensive standard treatment in reducing the intensity of drinking in study patients. Female heavy drinkers studied at two sites (Australia and USA) reduced their drinking at follow-up regardless of whether they were assigned to the intervention conditions or the control group.

To provide a clinical perspective to the findings, Chapter 15 presents representative case reports written by the health advisers at each collaborating centre. This chapter also explores the process of change that may be involved in a successful response to brief intervention.

Following the clinical perspectives of the health advisers, Chapter 16 describes a series of combined analyses based on pooled data from the eight centres that implemented the core study design. These analyses not only summarize the cross-national findings, they also explore various moderator variables that help to explain the results. The combined analyses show a significant effect of the interventions on both average alcohol consumption and intensity of drinking in the male samples, even after controlling for demographic factors and sociocultural influences. For females significant reductions were observed in both the control and the intervention groups. The results also showed that the intensity of the intervention was not related to the amount of change in drinking behaviour, with five minutes of simple advice as effective as 20 minutes of brief counselling.

Male patients exposed to the interventions reported approximately 25% less daily alcohol consumption than those in the control group. Relative reductions in the intensity of drinking were approximately 16%. The results indicate that without brief interventions, 42% reduce their drinking by one standard drink (1.5 cl) or more, 25% increase their drinking, and 33% do not change. With intervention, 63% reduce their drinking, 14% drink more intensely, and 23% remain at the same level. Assuming that the consequences of acute intoxication are the main health risks for patients in these samples, and taking into account the improvement that can be expected spontaneously in 40% of the patients, the results suggest that approximately one in five (20%) of the patients exposed to a brief intervention will respond favourably. The results of both the mean comparisons and percentage changes indicate that there was a significant reduction in dependence symptoms, and a trend ($p < .05$) towards reductions in concern expressed by others and alcohol-related problems. While the numbers affected are small, they do suggest that the social, occupational and health consequences of heavy drinking and intoxication could be reduced if brief interventions were employed routinely.

For females significant reductions were observed in both the control and the intervention groups, although there is some indication in the comparisons of percentage changes that the Brief Counselling group improved more. A conservative interpretation of the results is that brief interventions *per se* do not contribute as much to the reduction of heavy drinking in females as they do in males.

A number of personal and social characteristics were evaluated as possible moderators of the patient's response to the interventions. Only one variable showed a clear relation to the type of intervention: simple advice worked best for male patients who had experienced a recent alcohol-related problem, while brief counselling worked better for those who did not have a recent problem. These results suggest that the effect of minimal intervention is enhanced when the risks of hazardous drinking are consistent with the patient's personal experience.

Chapter 17 concludes the report with a general discussion of the findings and their implications for a public health approach to the early identification and secondary prevention of alcohol-related problems. Given the very promising results of the present project, it is recommended that brief intervention techniques receive widespread dissemination for use with heavy drinkers in primary care settings. Before this can be accomplished, however, additional research and planning are required to overcome barriers in the areas of early identification, training of primary care workers, and administrative support for secondary prevention.

Chapter 2

BACKGROUND TO THE STUDY

T.F. Babor

INTRODUCTION

Alcohol-related disabilities have become a major source of concern in primary health care in both developed and developing countries (1). In spite of the social, medical and economic costs of alcohol-related problems, traditional approaches to the management of "alcoholism" have favored labour intensive medical and social rehabilitation over early identification and secondary prevention. In 1980 a WHO Expert Committee (1) stressed the need for efficient methods to detect persons with harmful alcohol consumption before health and social consequences become pronounced, and called for the development of strategies that could be applied in primary health care settings with a minimum of time and resources.

These recommendations came at a time when efforts to implement a public health approach to alcohol-related problems had been initiated in several countries with promising results. These efforts were designed to link a new generation of screening technologies to low-cost early intervention strategies (2). The impetus for these programmes came in part from broader public health concern with the relationship between lifestyle-related behavioural risk factors and disease prevalence (3). Because lifestyle risk factors such as cigarette smoking, lack of exercise and excessive alcohol consumption are often amenable to brief interventions, increasing attention has been devoted to the development of behaviour change programmes that could be implemented in primary care.

Other reasons for the growing interest in alcohol screening and brief intervention are the apparent effectiveness of various behaviour change techniques; the need to conserve health care resources, especially in developing countries; the intuitive appeal of early intervention as a means of preventing the development of alcohol dependence; changes in the conceptualization of alcohol-related disabilities (2,4,5); and evidence suggesting that the burden of illness imposed on society by heavy drinkers is comparable to that imposed by alcoholics (6).

Within this context, the WHO Collaborative Project on Identification and Management of

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